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*Attorneys for Complainant*

**BEFORE THE**
**BOARD OF REGISTERED NURSING**
**DEPARTMENT OF CONSUMER AFFAIRS**
**STATE OF CALIFORNIA**

| | |
|---|---|
| In the Matter of the Accusation Against:<br><br>**KATHLEEN FILIAGGI**<br>**147 Hemlock Drive**<br>**Elyria, OH 44035**<br><br>**Registered Nurse License No. 594440**<br><br>Respondent. | Case No. 2013-428<br><br>**A C C U S A T I O N** |

Complainant alleges:

## PARTIES

1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about February 6, 2002, the Board of Registered Nursing issued Registered Nurse License Number 594440 to Kathleen Filiaggi ("Respondent"). Respondent's registered nurse license expired on March 31, 2010.

## JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing ("Board"), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Code section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

6. Code section 2761 states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct . . .
>
> . . . .
>
> (4) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a health care professional license or certificate by another state or territory of the United States, by any other government agency, or by another California health care professional licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that action . . .

## COST RECOVERY

7. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licentiate to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

## CAUSE FOR DISCIPLINE

**(Disciplinary Action by the Ohio Board of Nursing)**

8. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(4), on the grounds of unprofessional conduct, in that she was disciplined by the Ohio Board of Nursing ("Ohio Board"), as follows: On or about July 30, 2010, pursuant to Adjudication Order 1937 in the disciplinary proceeding titled "In the Matter of: Kathleen Filiaggi,

R.N.", Case No. 09-4431, 09-1004, the Ohio Board suspended Respondent's license to practice as a registered nurse in the state of Ohio for an indefinite period of time, effective August 9, 2010, and that following reinstatement, Respondent's license shall be subject to a stayed suspension under probationary terms, conditions, and limitations for a minimum period of one (1) year. True and correct copies of Adjudication Order 1937 and the related Report and Recommendation of Beth A.Lewis, the Hearing Examiner, is attached as **exhibit A** and incorporated herein. The Board accepted certain Findings of Fact in the Hearing Examiner's Report and Recommendation, including the following:

a. Respondent was employed as a registered nurse at St. John Westshore hospital from October 2007 to March 2009, with no disciplinary action on her employment record up until the time of her removal.

b. On or about March 6, 2009, Respondent was assigned to work the 7 p.m. to 7 a.m. shift in the critical care unit at St. John Westshore hospital. She was assigned to care for 2 patients.

c. Patient #1 suffered from bi-polar disorder and was off all of her medications. Patient #1 was not supposed to leave her room. Patient #1 was agitated, repeatedly left her room and walked out into the hall. Respondent repeatedly asked Patient #1 to return to her room.

d. Patient #1 became upset and asked for Respondent's name. Respondent provided her first name, but declined to give Patient #1 her last name. Patient #1 repeatedly asked for Respondent's last name, and Respondent continued to provide her first name only. This aggravated Patient #1.

e. Patient #1 again left her room, went to the nurses' station, and asked for a pen to use. Respondent provided a pencil. Respondent walked around the nurses' desk to help Patient #1 back to her room.

f. While standing in the hallway, Respondent stated that Patient #1 raised her right arm toward Respondent, and Respondent blocked the patient's arm with her left hand and grasped the patient's arm with her left hand. Respondent stated that Patient #1 moved to within 2 inches of Respondent's face, and screamed and spewed saliva in Respondent's face. The Hearing Examiner

found that at a minimum, Respondent grabbed the patient's jaw in the chin area and used enough force to get Patient #1 to back away from Respondent. Respondent stated to Patient #1, "You are not going to hit me, you are not going to touch me." Respondent denied grabbing Patient #1 by the throat. At 3:30 a.m., a nurse observed a dime-sized redness visible on the right side of Patient #1's neck.

g. Respondent's employment with St. John Westshore hospital was terminated approximately 5 days after the incident.

h. On or about June 8, 2009, in the Rocky River Municipal Court, Cuyahoga County Case No. 09 CRB 481, Respondent was found guilty, after a jury trial and by a jury verdict, of Assault, a first-degree misdemeanor, in violation of Section 2903.13(A), ORC.

**PRAYER**

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 594440, issued to Kathleen Filiaggi;

2. Ordering Kathleen Filiaggi to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: November 27, 2012

for LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
*Complainant*

SA2012106442

**EXHIBIT A**

**Adjudication Order 1937, Ohio Board of Nursing Case No. 09-4431, 09-1004**

Ohio Board of Nursing www.nursing.ohio.gov
17 South High Street, Suite 400 • Columbus, Ohio 43215-7410 • (614) 466-3947

# BEFORE THE OHIO BOARD OF NURSING

IN THE MATTER OF:

ORDER: 1937
CASE # 09-4431, 09-1004

KATHLEEN FILIAGGI, R.N.

CERTIFIED TO BE A TRUE COPY
Carol A. Ellenwood 3/26/10
OHIO BOARD OF NURSING

## ADJUDICATION ORDER

This matter came on for consideration before the Ohio Board of Nursing (hereinafter "Board") on July 30, 2010. At such time the Board verified that it reviewed the following materials prior to consideration of this matter:

Hearing Transcript; State's Exhibits; Respondent's Exhibits; and Report and Recommendation.

Beth A. Lewis was the Hearing Examiner designated in this matter pursuant to Section 119.09, Ohio Revised Code (ORC). *A true copy of the Report and Recommendation of Beth A. Lewis is attached hereto and incorporated herein.*

On this date, the Board accepted all of the Findings of Fact, Conclusions of Law, and modified the Recommendation in the Hearing Examiner's Report and Recommendation and ORDERED that **KATHLEEN FILIAGGI's** license to practice nursing as a registered nurse in the State of Ohio is hereby suspended for an indefinite period of time with the conditions for reinstatement set forth below, and that following reinstatement, **MS. FILIAGGI's** license shall be subject to probationary terms, conditions, and limitations set forth below for a minimum period of one (1) year.

The rationale for this modification is that the Board, in its expertise, believes that **MS. FILIAGGI** was placed in a difficult situation due to her patient assignment and work environment and that **MS. FILIAGGI** reacted in a defensive manner because she felt threatened. Based upon these circumstances and the nurse's numerous years of practice with no prior Board action, and the letters of support regarding **MS. FILIAGGI** and her practice, the Board does not believe that **MS. FILIAGGI** is likely to re-offend. While it is not excusable for a nurse to respond in the manner in which **MS. FILIAGGI** did, the consequences **MS. FILIAGGI** has received are adequate and do not demean the significance of the offense. **MS. FILIAGGI** has completed anger management, a mental health assessment in 2006, and 80 hours of community work service. The Board does not believe that a lengthy suspension and practice restrictions are necessary to protect the public in this set of circumstances.

REQUIREMENTS AND CONDITIONS FOR REINSTATEMENT

1. **MS. FILIAGGI** shall obey all federal, state, and local laws, and all laws and rules governing the practice of nursing in Ohio.

2. **MS. FILIAGGI** shall appear in person for interviews before the full Board or its designated representative as requested by the Board or its designee.

3. **Prior to seeking reinstatement by the Board, MS. FILIAGGI** shall submit a request to the Bureau of Criminal Identification and Investigation (BCII) to conduct a criminal records check of **MS. FILIAGGI,** including a check of Federal Bureau of Investigation (FBI) records, and shall cause BCII to submit **MS. FILIAGGI's** criminal records check reports to the Board. A request for reinstatement will not be considered by the Board until the completed criminal records check, including the FBI check, has been received by the Board.

4. Prior to seeking reinstatement by the Board, **MS. FILIAGGI** shall, at her own expense, obtain a psychiatric evaluation from a Board approved psychiatrist and shall provide the Board with complete documentation of such evaluation. Prior to the evaluation, **MS. FILIAGGI** shall provide the psychiatrist with a copy of this Order and Notice of Opportunity for Hearing and shall execute releases to permit the psychiatrist to obtain any information deemed appropriate and necessary for the evaluation. The psychiatrist shall submit a written opinion to the Board that includes diagnoses, recommendations for treatment and monitoring, any additional restrictions that should be placed on **MS. FILIAGGI's** license, and a statement as to whether **MS. FILIAGGI** is capable of practicing nursing according to acceptable and prevailing standards of safe nursing care.

5. **MS. FILIAGGI** shall provide the Board with satisfactory documentation of compliance with all aspects of the treatment plan developed by the psychiatrist described above until released. Further, the Board may utilize the professional's recommendations and conclusions from the evaluation as a basis for additional terms, conditions, and limitations on **MS. FILIAGGI's** license.

**Reporting Requirements of MS. FILIAGGI**

6. **MS. FILIAGGI** shall sign release of information forms allowing health professionals and other organizations to submit requested documentation or information directly to the Board.

7. **MS. FILIAGGI** shall submit any and all information that the Board may request regarding her ability to practice according to acceptable and prevailing standards of safe nursing practice.

8. **MS. FILIAGGI** shall not submit or cause to be submitted any false, misleading, or deceptive statements, information, or documentation to the Board or to employers or potential employers.

9. **MS. FILIAGGI** shall submit the reports and documentation required by this Order on forms specified by the Board. All reporting and communications required by this Order shall be made to the Compliance Unit of the Board.

10. **MS. FILIAGGI** shall submit the reports and documentation required by this Order to the attention of the Compliance Unit, Ohio Board of Nursing, 17 South High Street, Suite 400, Columbus, OH 43215-7410.

11. **MS. FILIAGGI** shall verify that the reports and documentation required by this Order are received in the Board office.

12. **MS. FILIAGGI** shall inform the Board within three (3) business days, in writing, of any change in address and/or telephone number.

## DURATION

The Board may only alter the indefinite suspension imposed if: (1) **MS. FILIAGGI** submits a written request for reinstatement; (2) the Board determines that **MS. FILIAGGI** has complied with all conditions of reinstatement; and (3) the Board determines that **MS. FILIAGGI** is able to practice according to acceptable and prevailing standards of safe nursing care based upon an interview with **MS. FILIAGGI** and review of the documentation specified in this Order.

**Following reinstatement, MS. FILIAGGI shall be subject to the following probationary terms, conditions, and limitations for a minimum period of one (1) year.**

1. **MS. FILIAGGI** shall obey all federal, state, and local laws, and all laws and rules governing the practice of nursing in Ohio.

2. **MS. FILIAGGI** shall appear in person for interviews before the full Board or its designated representative as requested by the Board or its designee.

### Employment Conditions

3. Prior to accepting employment as a nurse, each time with every employer, **MS. FILIAGGI** shall notify the Board.

4. **MS. FILIAGGI** shall have her employer(s), if working in a position where a nursing license is required, submit written reports regarding job performance on a quarterly basis. **MS. FILIAGGI** shall provide her employer(s) with a copy of this Order and Notice of Opportunity for Hearing and shall have her employer(s) send documentation to the Board, along with the first employer report, of receipt of a copy of this Order and Notice of Opportunity for Hearing, including the date they were received. Further, **MS. FILIAGGI** is under a continuing duty to provide a copy of this Order and Notice of Opportunity for Hearing to any new employer prior to accepting employment.

### Reporting Requirements of MS. FILIAGGI

5. **MS. FILIAGGI** shall sign releases of information forms allowing health professionals and other organizations to submit the requested documentation directly to the Board.

6. **MS. FILIAGGI** shall submit any and all information that the Board may request regarding her ability to practice according to acceptable and prevailing standards of safe nursing practice.

7. **MS. FILIAGGI** shall not submit or cause to be submitted any false, misleading, or deceptive statements, information, or documentation to the Board or to employers or potential employers.

8. **MS. FILIAGGI** shall submit the reports and documentation required by this Order on forms specified by the Board. All reporting and communications required by this Order shall be made to the Compliance Unit of the Board.

9. **MS. FILIAGGI** shall submit the reports and documentation required by this Order or any other documents required by the Board to the attention of the Compliance Unit, Ohio Board of Nursing, 17 South High Street, Suite 400, Columbus, OH 43215-7410.

10. **MS. FILIAGGI** shall verify that the reports and documentation required by this Order are received in the Board office.

11. **MS. FILIAGGI** shall inform the Board within five (5) business days, in writing, of any change in employment status or of any change in residential or home address or telephone number.

12. Prior to working as a nurse, if requested by the Board or its designee, **MS. FILIAGGI** shall complete a nurse refresher course or extensive orientation approved in advance by the Board.

FAILURE TO COMPLY

**The stay of MS. FILIAGGI's suspension shall be lifted and MS. FILIAGGI's** license to practice nursing as a registered nurse will be automatically suspended if it appears to the Board that **MS. FILIAGGI** has violated or breached any terms or conditions of this Order. Following the automatic suspension, the Board shall notify **MS. FILIAGGI** via certified mail of the specific nature of the charges and automatic suspension of her license. Upon receipt of this notice, **MS. FILIAGGI** may request a hearing regarding the charges.

DURATION

The Board may only alter the probationary period imposed by this Order if: (1) the Board determines that **MS. FILIAGGI** has complied with all aspects of this Order; and (2) the Board determines that **MS. FILIAGGI** is able to practice according to acceptable and prevailing standards of safe nursing care without Board monitoring, based upon an interview with **MS. FILIAGGI** and review of the reports as required herein. Any period during which **MS. FILIAGGI** does not work in a position for which a nursing license is required shall not count toward fulfilling the probationary period imposed by this Order.

The Board further Orders **KATHLEEN FILIAGGI** to surrender her registered nurse license, R.N. #277298, immediately.

This ORDER shall become effective immediately upon the date of mailing indicated on the attached Certificate of Service and is hereby entered upon the Journal of the Board for the 30st day of July, 2010.

## TIME AND METHOD TO PERFECT AN APPEAL

Any party desiring to appeal shall file a Notice of Appeal with the Ohio Board of Nursing, 17 S. High St., Ste 400, Columbus OH 43215-7410, setting forth the order appealed from and the grounds of the party's appeal. A copy of such Notice of Appeal shall also be filed by the appellant with the Franklin County Court of Common Pleas, Columbus, Ohio. Such notices of appeal shall be filed within fifteen (15) days after the mailing of the notice of the Ohio Board of Nursing's Order as provided in Section 119.12 of the Ohio Revised Code.

## CERTIFICATION

The State of Ohio
County of Franklin

I, the undersigned Betsy J. Houchen, Executive Director for the Ohio Board of Nursing, hereby certify that the foregoing is a true and exact reproduction of the original Order of the Ohio Board of Nursing entered on its journal, on the 30st day of July, 2010.

Betsy J. Houchen

Betsy J. Houchen, R.N., M.S., J.D.
Executive Director

July 30, 2010
Date

(SEAL)

# CERTIFICATE OF SERVICE

I hereby certify that a true and accurate copy of the foregoing Order concerning, **KATHLEEN FILIAGGI**, was sent via certified mail, return receipt requested, this 9 day of August, 2010 to **KATHLEEN FILIAGGI,** 147 Hemlock Drive, Elyria, Ohio, 44035 and Elizabeth Y. Collis, Attorney for **KATHLEEN FILIAGGI**, 1650 Lake Shore Drive, Suite 225, Columbus, Ohio, 43204.

I also certify that a copy of the same was sent via regular U.S. mail this 9 day of August, 2010 to Lamont Pugh, SAC, Sanctions & Exclusions, Department of Health and Human Services, Office of Inspector General, Office of Investigations, PO Box 81020, Chicago, IL 60601-81020.

Betsy J. Houchen

Betsy J. Houchen, R.N., M.S., J.D.
Executive Director

tlb

cc: Melissa L. Wilburn, Assistant Attorney General

Certified Mail Receipt No. 7009 1680 0001 8226 9759
Attorney Certified Mail Receipt No. 7009 1680 0001 8226 9766

State of Ohio
Board of Nursing
17 South High Street, Suite 400
Columbus, Ohio 43215-7410



In the Matter of
Kathleen Filiaggi, R.N.
Respondent

Beth A. Lewis, Esq.
Hearing Examiner

Case No. 09-1004; 09-4431

June 18, 2010
Report and Recommendation

Appearances: For the Ohio Board of Nursing: Richard Cordray, OHIO ATTORNEY GENERAL, and Melissa L. Wilburn, Esq., Assistant Attorney General, Health & Human Services Section, 30 East Broad Street, 26th Floor, Columbus, Ohio 43215-3428 Telephone: 614-466-8600; Fax: 614-466-6090.

For the Licensee/Respondent: Elizabeth Y. Collis, Esq., Collis, Smiles & Collis, LLC, 1650 Lake Shore Drive, Suite 225, Columbus, Ohio 43204. Telephone: 614-486-3909; Fax: 614-486-2129.

**Nature of the Case**

This is an administrative proceeding under Chapter 119 (the Administrative Procedure Act), and Chapter 4723 (the Nurse Practice Act), of the Ohio Revised Code ("ORC"). The case involves a Notice of Opportunity for Hearing issued to the Respondent, Kathleen Filiaggi, R.N. ("Respondent" or "Ms. Filiaggi"), on November 20, 2009. In the notice sent to Ms. Filiaggi, the Ohio Board of Nursing ("Board") informed Ms. Filiaggi that it intended to take disciplinary action against her license based on Ms Filiaggi assaulting a patient, and being found guilty of Assault, a first-degree misdemeanor, committed against a patient in the course of practice. (State Exhibit 1.) In the notice, the Board set forth its reasons for the proposed action, identified the charges against her, and advised Ms. Filiaggi of her right to a hearing. (*Id.*) Ms. Filiaggi made a timely request for a hearing. (State Exhibit 2 ) The Board appointed me to serve as its Hearing Examiner. A hearing was conducted on May 13, 2010, at which the parties presented their evidence on the charges against Ms. Filiaggi. Ms. Filiaggi was present at the hearing and was represented by counsel. This report is based on the testimony and evidence presented at the hearing.

**Summary of the Issues**

The Board charged Ms. Filiaggi with being found guilty of Assault, a first-degree misdemeanor, committed against a patient during the course of her practice, which is in turn a violation of Section 4723.28(B)(3), ORC. This Section authorizes the Board to discipline a licensee for conviction of, a plea of guilty to, a judicial finding of guilt of, a judicial finding of guilty resulting from a plea of no contest to, or a judicial finding of eligibility for intervention in lieu of conviction for, or a misdemeanor committed in the course of practice. The Board also charged Ms. Filiaggi with violating Section 4723.28(B)(12), ORC, which authorizes the Board to discipline a licensee for assaulting or causing harm to a patient or depriving a patient of the means to summon assistance. Finally, the Board charged Ms. Filiaggi with a violation of Section 4723.28(B)(16), ORC, which authorizes the Board to discipline a licensee for a violation of Chapter 4723, ORC, or any rules adopted under it. Specifically, Rule 4723-4-06(K), Ohio Administrative Code ("OAC"), states that a licensed nurse shall not: (1) Engage in behavior that causes or may cause physical, verbal, mental, or emotional abuse to a client; (2) Engage in behavior toward a client that may reasonably be interpreted as physical, verbal, mental, or emotional abuse. Certified copies of the documents relating to Ms. Filiaggi's criminal conviction in Rocky River Municipal Court, Cuyahoga County Case No. 09 CRB 481, were admitted into evidence by the State. (State Exhibit 7.)

The Board is required to consider the merits of each case, and may, based upon the circumstances leading to these charges, consider both aggravating and mitigating circumstances shown in the record. From the evidence before me, I find a sufficient basis to conclude that the charges against Ms. Filiaggi have been proved. On or about June 8, 2009, in Rocky River Municipal Court, Cuyahoga County Case No. 09 CRB 481, Ms. Filiaggi was found guilty, after a jury trial and by a jury verdict, of Assault, a first-degree misdemeanor in violation of Section 2903.13(A), ORC. (Factual Stipulation #5; State Exhibit 7.) The acts underlying Ms. Filiaggi's conviction occurred on or about March 6, 2009, when Ms. Filiaggi grasped a patient around the jaw in the chin area, and used enough force to get the patient to back away from her. (*See* Factual Stipulation #23; *see* Tr., pp. 184-185.) Because the Respondent stipulated to the criminal conviction and her actions, the remaining issue to be decided in this case is the sanction to be imposed. Because the evidence establishes a valid basis for disciplinary action, and after considering the evidence in aggravation and in mitigation, I recommend that Ms. Filiaggi's

license to practice as a registered nurse be suspended for an indefinite period of time, but not less than two (2) years, with conditions for reinstatement as outlined below; and that following reinstatement, Ms. Filiaggi be subject to a stayed suspension under probationary terms, conditions, and limitations for a minimum period of three (3) years, with the permanent practice restrictions outlined below. My analysis follows.

**Evidence Examined**

The State and Respondent presented evidence through the stipulated exhibits identified in the record at pages 4 and 5 of the transcript of proceedings. (State Exhibits 1 – 11; Respondent Exhibits B – Q-7.) The parties also submitted a document of "Agreed Stipulations" which contained twenty-five (25) stipulations of fact. (Tr., pp. 7-8.) The State submitted an additional exhibit identified as "D Corrigan Certificates," which was admitted without objection. (State Exhibit 12; Tr., pp. 29, 73.) The State presented the testimony of Dennis Corrigan, Board Investigator. The Respondent presented the testimony of William Warax, client of Ms. Filiaggi; Cheryl Volk, R.N.; Rita Fitch, R.N.; Colleen Ridenour, L.P.N.; and Shelley A. Nowak, R.N. Ms. Filiaggi also testified on her own behalf. All testimony and exhibits admitted in the hearing of the matter, whether or not specifically referred to in this Report, were thoroughly reviewed and considered by the Hearing Examiner prior to the entry of the findings, conclusions, and recommendations shown below.

**Summary of the Evidence**

The parties presented evidence that Ms. Filiaggi has been licensed to practice nursing as a registered nurse in the State of Ohio since March 3, 1998. (State Exhibit 5.) Ms Filiaggi has also been licensed in California, Hawaii, Minnesota, New Jersey, New York, and Washington. (Factual Stipulation #4.) Ms. Filiaggi's licenses in these other states have lapsed because she did not renew them. (Factual Stipulation #4; Tr., p 152.) Ms. Filiaggi worked as a travel nurse for eight (8) years, mostly in emergency room/trauma center settings. (*See* Tr., p. 153-154.) Ms Filiaggi, who is from the Cleveland area, also began working for Elyria Memorial Hospital ("EMH") in 2003, during the periods of time she was not serving as a travel nurse (Tr., p. 156.) By 2009, Ms. Filiaggi had given up the travel nursing, but held four (4) nursing positions in the Cleveland area: nurse at EMH and St. John Westshore hospital ("SJWS"), paramedic instructor

for Lorain County Community College, and agency nurse for Advanced Medical Infusion (Tr, p. 156.) At SJWS, Ms Filiaggi worked in the critical care float pool on an "as needed" basis. (Tr., p. 156.)

On March 6, 2009, Ms. Filiaggi was assigned to work in the Intensive Care Unit ("ICU") at SJWS during the 7 p.m. to 7 a.m. shift. (Factual Stipulation #7 ) She was assigned to care for two (2) patients that evening: Patient #1, a bi-polar patient who was off her psychiatric medications (Factual Stipulation #8), and Patient #2, a critical patient suffering from respiratory issues (Factual Stipulation #25; Tr., p. 158) Upon receiving the report from the day-shift nurse, Ms. Filiaggi learned that Patient #1 was waiting to be medically cleared so that she could be transferred to the EMH psychiatric unit. (State Exhibit 11.) SJWS did not have a psychiatric unit. (Tr., p. 86.) Ms. Filiaggi also learned that Patient #1 had been "unruly all day by taking off her monitor and BP cuff and getting out of bed multiple times even though instructed not to She was reported to have her heat cranked up, window open and had hit the code blue button in the room. The day shift nurse stated she was done babysitting the pt [sic.] and had left her off the monitor." (State Exhibit 11; *see also*, Respondent Exhibit M.) Patient #1 had initially been "pink-slipped," meaning that she was involuntarily committed to the hospital for seventy-two (72) hours, and was not allowed to check herself out of the hospital. (Factual Stipulation #9 ) However, at the time of the incident in question, the patient was no longer "pink-slipped." (*See* State Exhibit 11.)

After receiving the report from the day-shift nurse, Ms. Filiaggi assessed Patient #1. (Tr., p. 158.) Ms. Filiaggi explained that she made contact with Patient #1 first because this patient was not as critical as Patient #2. (Tr , p. 160.) She also wanted to introduce herself to Patient #1 and "set limits" for Patient #1. (*Id.*) Ms. Filiaggi described her initial contact with Patient #1 as follows:

> [ ] I said, I know that you have had some difficulty during the day with nurses on day shift I know you have been allowed up several times, but that's not how it goes in the ICU You're on a monitor for a reason Until you're medically cleared and transferred to another unit, I can't have you getting up out of the bed If you need assistance, please call me on the call bell
>
> I gave her the call bell, put it next to her [ ] I asked her, Please don't take things off. I'll come in and assist you if you have to go to the bathroom and what have you I'll be glad to come in and help you, I said In the meantime, we are going to try to get you transferred over to the EMH psych unit and we will go from there

(Tr., pp. 161-162 ) The patient initially agreed with the conditions as outlined by Ms Filiaggi (*See* State Exhibit 11, Tr., p. 161.) The patient also told Ms. Filiaggi that she needed her

medications for the night. (Tr , p 162 ) Ms Filiaggi explained that no medications had been ordered for her, but when she got a chance, she would contact the doctor for medication orders. (*Id* )

Ms. Filiaggi described her later contact with Patient #1:

> The pt. called on the call bell at 10 p m to go to the bathroom and I went in the room and unhooked her from the monitor The pt. went to the bathroom and then I hooked her back up to the monitor and SCD's She then asked me about the medications she was supposed to take at night She stated that the psych doctor was supposed to get them clarified for her earlier I told her I would look in her chart for the dosages and look into the fact why her meds weren't received I then had my other pt begin to deteriorate and I ended up being in his room for approximately 2-2½ hrs intubating him and dealing [with] blood pressure issues. At one time, the nurse tech came in the room to tell me that [Patient #1] wanted to know where her meds were I instructed the nurse tech . to tell the pt I would be with her soon and that I needed to get the dosages clarified Approximately around 0030, the nurse tech was in the hallway [with Patient #1] stating she needed to go for a walk around the unit The pt proceeded to argue [with] me about her medications I tried to explain to her that I was dealing [with] a very sick pt and that I would be glad to take care of that as soon as possible. In the process of arguing [with] the pt, I found out from the charge nurse that the pt's doctor had come in to see the pt around 10ish. I told Bob Buchnovich RN (the charge nurse) that I was needing to talk to Dr Corpus regarding the pt's medications and why didn't anyone come tell me he was here He said that Dr Corpus had wrote orders So I looked at the chart and looked at the orders I proceeded to tell the pt to come in her room and we can discuss this further in her room rather than the hallway The pt went into her room and proceeded to argue more [with] me about her medications I asked her why she didn't ask the doctor about her medications when he came in to see her I told her I would page the doctor and get them clarified for her I paged Dr Corpus through his answering service 15 minutes had gone by and no page returned The pt was asking again why she didn't have her meds yet I explained to her that I paged the doctor and that I didn't hear back from him yet. I told her I would repage him again She continued to argue [with] me that the psych doctor should have gotten the dosages earlier I repaged Dr Corpus and got the meds ordered for her [Sic ]

(State Exhibit 11 )

Patient #1 continued to get up and leave her room several times throughout the night. (*See* Tr., p. 170.) Ms Filiaggi redirected Patient #1 back to her room each time. Other nurses on the unit heard Patient #1 yelling that night, or were aware that Patient #1 was being difficult (*See* Tr., pp. 89, 113, 172.) Once Patient #1 received medical clearance for transfer to the EMH psychiatric unit, Ms Filiaggi began working on that process. (*See* Tr., p. 169.) When Ms. Filiaggi told Patient #1 that she was about to be transferred, Patient #1 became upset; she did not want to be transferred in the middle of the night. (State Exhibit 11 )

At around 1:00 a.m., Ms. Filiaggi asked for assistance with Patient #1 from her co-workers while she went to get something to eat. (Tr., p. 240 ) She described the conversation as follows: ". . . Do you guys mind watching the patient? She keeps coming out of her room. Do you need to call security? No, no, no, she's fine [the other nurses answered]. We don't need

anybody. She'll be all right. They kind of laughed at it." (Tr., pp. 171-172.) Ms Filiaggi did not leave the floor to get something to eat. (Tr., p. 240.)

The situation with Patient #1 continued to escalate. Ms. Filiaggi stated that Patient #1 would call her, using the call button, even though she could see Ms Filiaggi sitting at the nurses' station just across the hallway from her room (Tr., p. 172.) Patient #1 asked for the names of the people providing her care. (Tr., p. 172.) Ms. Filiaggi provided the doctor's name, and stated she would look up the psychiatrist's name in the chart. (State Exhibit 11; *see* Tr., p. 172.) Ms Filiaggi provided her own first name, but refused to give the patient her last name. (State Exhibit 11.) Patient #1 was using a dry erase marker from her room to write down all of the names. (Tr., p. 172; State Exhibit 11.) A short while later, Patient #1 again left her room and approached Ms. Filiaggi who was sitting at the nurses' station. (State Exhibit 11.) Patient #1 asked for a pen with which to write, because the dry erase marker was too big. (*Id.*) Ms. Filiaggi could not find an extra pen, and so gave Patient #1 a small menu pencil. (Tr., p. 178.) Patient #1 asked, "Is this what you guys write with around here?" (Tr., p. 179.) Ms. Filiaggi responded, "This is what we have. Take it or leave it." (*Id.*) Ms. Filiaggi also asked, "What do you need a pen for anyway?" (*Id.*)

Ms. Filiaggi stated she then came around the desk to take Patient #1 back to her room. (Tr., p. 179.) She stated, "... Let's just go back into your room. And she [the patient] raised her right arm like she was going to punch me, hit me or whatever." (Tr., p. 180.) Ms. Filiaggi "thought [Patient #1] had grabbed the pencil from the desk, because that's what she came out for. I thought she had that in her hand. [...] I thought maybe she had the pencil in her hand and was going to stab me with it or punch me. I had no idea what she was going to do." (Tr., p. 182.)

Ms. Filiaggi described the altercation:

Q So she raised her right arm
A Correct
Q And what did you do?
A I blocked it with my left arm
Q Describe for me . how [you] blocked it
A Grabbed it like that She raised it; I grabbed it
Q And then what did you do?
A I held that there, and the look on her face, it happened so fast, she came within two inches of my face
Q Once you held her arm, did she step towards you or away?
A She stepped towards me
Q She stepped closer to you?
A Right She stepped within two inches of my face into my personal space
[ ]

Q Okay And what did she do when she approached you that closely?
A She had a look on her face, she was so angry, and she was yelling at me so much, when people get so mad at you they're spraying their saliva at you And she's like, You're not going tell me to go back into my room, screaming, whatever she said, and that's when I just kind of reacted.
Q What did you do?
A I grabbed her chin, jaw, tried to keep it closed and turn it to the side so she couldn't spit at me, bite me, head butt me I didn't know what she was capable of doing at that point My only reaction I could think I didn't want to push her. I didn't want to hit her I mean, I couldn't even put my hand up to block her because she was so close to me
[ ]
Q Okay So for the record, your thumb would have been on one side of her jaw and then your index finger and maybe second or third fingers would have been on the other side of her jaw
A Correct
Q Your hand was in a V position?
A Correct Correct, similar to when you're holding C spine, kind of the same thing
Q Describe the amount of pressure you put on her chin
A Enough to get her back away from me
[ ]
Q Who came to assist you at that point?
A John came from down the hall Kurt came from behind, and Bob came from the other hallway
Q. Did you – what did you say to the patient?
A I don't know what my quote was, but I said, You are not going to touch me You're not going to hit me
Q Did you threaten her?
A Absolutely not
Q What was her response?
A She started screaming that I was choking her.
Q. At any time did your hand touch her neck?
A Absolutely not

(Tr., pp. 182-186.)

The three nurses who witnessed the altercation provided accounts that differed in aspects from Ms. Filiaggi's. John Staunton, the nurse who came from down the hall, described the incident as follows:

> I John Staunton RN witnessed Kath RN in the hallway of the ICU place her hand on Patients throat during an altercation. The patient was asking a question (last name of Kathy) who told her she does not give that out. At that time the patient and Kathy were very close together The patient placed her hand on Kathy's arm Kathy then grabbed the Pt by the neck and said "Nobody touches me, and if you touch me again I'll choke you again " [Sic ]

(State Exhibit 8 ) At 3:30 a.m., Mr. Staunton charted that Patient #1 had a "dime sized redness noted to right side of neck Chin is free of injuries." (*Id* )

Kurt Kless, the nurse who approached the scene from behind Ms. Filiaggi, wrote,

> [Patient #1] came to nurse station Asked Kathy RN for her last name Kathy replied that she would not give it to her Kathy then went to check an alarm in another room Kathy then approached the pt rapidly, stoping [sic ] only a few inches from her With a raised voice she told the pt to get back in her room, and that this was the "last time I'm going to tell you " The pt placed her hand on Kathy's arm in what appeared to be a gental [sic ], non-aggressive way Kathy

then grabed [sic ] the pt forcefully by the throat with her right hand At this time another RN and I stepped in to separate [sic ] the two

(State Exhibit 9.)

Robert Buchnavich, the charge nurse who came from the other hallway, stated, "Concerning [Patient #1]. I was making out morning assignments @ the back board when I heard shouting and arguing. Kathy Filiaggi was arguing with her patient saying "you don't ever touch me." John Staunton told me that Kathy RN grabbed her by the throat I took Kathy off her assignment and she left the floor. Nursing supervisor called and updated [Sic.]" (State Exhibit 10.)

None of these three witnesses claimed that the patient raised her arm towards Ms. Filiaggi (*See* State Exhibits 7, 8, 9.) Two of the witnesses stated only that the patient "*placed* her hand on Kathy's arm. . ." (State Exhibits 7, 8.)

After the incident, Mr. Buchnavich took Patient #1 to a chair in the hallway where she remained (State Exhibit 11.) Ms. Filiaggi contacted security (*Id.*) Ms. Filiaggi gave reports on her patients to two other nurses before she left the floor. (*Id*) The Westlake Police Department was contacted and a police officer came to the hospital. (*See* State Exhibit 11; *see* Tr., p 189 ) Ms. Filiaggi was sent home after writing her statement for the police. (Tr., p 189.) She was initially suspended, and then terminated from SJWS five (5) days later. (*Id*)

The State presented the testimony of Board Compliance Agent Dennis Corrigan regarding appropriate techniques to deal with difficult patients and Ms. Filiaggi's failure to act appropriately in her altercation with Patient #1. His testimony is discussed below under Aggravating/Mitigating Circumstances.

On our about June 8, 2009, in the Rocky River Municipal Court, Cuyahoga County Case No. 09 CRB 481, Ms Filiaggi was found guilty, after a jury trial and by a jury verdict, of Assault, a first-degree misdemeanor in violation of Section 2903 13(A), ORC. (Factual Stipulation #5; State Exhibit 7 ) Ms. Filiaggi has appealed her conviction; the appeal is currently pending. (Tr., p. 205.) Ms. Filiaggi was fined two hundred and fifty dollars ($250.00), sentenced to two (2) years community control, and ordered to complete eighty (80) hours of community service, an anger management program, nonviolent crisis intervention training at Elyria Memorial Hospital, and to participate in an assessment to determine whether Ms. Filiaggi

should attend additional training. (State Exhibit 7; Factual Stipulation #5.) Ms. Filiaggi reported her misdemeanor conviction on her 2009 licensure renewal application. (State Exhibit 6 )

On June 17, 2009, Ms. Filiaggi completed a nonviolent crisis intervention class as well. (Respondent Exhibit C.) On or about July 10, 2009, Ms. Filiaggi underwent an Anger Management and Aggression Control ("AMAC") Program assessment prior to attending the AMAC class. (*See* Respondent Exhibit D.) The assessor recommended that Ms. Filiaggi complete the AMAC Program and follow the conditions of her probation. (*Id*.) Ms. Filiaggi completed the AMAC class on July 18, 2009. (Respondent Exhibit B.) The AMAC Facilitator noted that Ms. Filiaggi was "attentive, cooperative, and actively participated in group sessions." (Respondent Exhibit E ) On or about July 18, 2009, Ms. Filiaggi participated in a mental health assessment. (*See* Respondent Exhibit F.) The assessor noted that Ms. Filiaggi "appeared alert, open and cooperative upon interview. At times she was emotional as she grieved over the changes this accusation has caused in her life. . . During a discussion of the events from that evening, Kathie admitted that her experience deescalating psychiatric patients was limited." (Respondent Exhibit F.)

At the hearing, Ms. Filiaggi submitted performance evaluations from EMH Regional Healthcare System for the time periods beginning in 2003, through 2009. (Respondent Exhibit H.) Ms Filiaggi also submitted evaluations from U.S. Nursing Corporation, the travel nursing organization for which she worked, for short periods of time in 2002 and 2006 (Respondent Exhibit I.) In addition, Ms. Filiaggi submitted documentation of reference checks she received in 2003 and 2004. (Respondent Exhibits J, K.) Ms. Filiaggi provided correspondence complimenting her on the service she provided to patients. (Respondent Exhibits L, O.) Ms Filiaggi also submitted seven (7) letters of recommendation and recognition written prior to the incident involving Patient #1. (Respondent Exhibit Q-1 through Q-7.) Ms Filiaggi's performance evaluations, reference checks, and letters of recommendation and recognition, all indicate she was a valued nurse and employee. (*See* Respondent Exhibits H, I, J, K.)

Finally, Ms. Filiaggi submitted forty-two (42) letters of support from her former co-workers, supervisors and patients, all written after her conviction. (Respondent Exhibits P-1 through P-42.) The letters describe a nurse dedicated to her profession (*see e g*, Respondent Exhibits P-1), filled with compassion for her patients (*see e g*, Respondent Exhibits P-5, P-9, P-22, P-32), and a zealous patient advocate (*see e g*, Respondent Exhibit P-11, P-17, P-24). Many

of Ms. Filiaggi's co-workers described how much the Respondent taught them as they worked together. (*See e g*, Respondent Exhibits P-20, P-34, P-41.)

The State recommended that Ms. Filiaggi's license to practice as a registered nurse be permanently revoked; or in the alternative, that Ms. Filiaggi's license be suspended indefinitely, that Ms. Filiaggi undergo a psychiatric evaluation and treatment prior to reinstatement, and that Ms Filiaggi's license be subject to permanent practice restrictions after reinstatement. (Tr., p. 256.) As part of its alternative recommendation, the State also requested that Ms. Filiaggi complete training in nursing ethics and dealing with combative patients. (*Id*.) The Respondent requested that any period of suspension be credited for the amount of time Ms. Filiaggi has been out of practice, that the suspension be stayed, and that Ms Filiaggi be placed on probation with no practice restrictions (Tr., p. 270.) Respondent noted that Ms. Filiaggi has already completed a psychiatric evaluation during which the assessor found no need for further counseling. (Tr., p. 271; *see* Respondent Exhibit F.) Respondent agreed that continuing education coursework on dealing with difficult patients and ethics would be appropriate (Tr., p. 270.)

**Analysis**

From the record now before the Board, it appears that there is a preponderance of evidence that on or about June 8, 2009, Ms. Filiaggi was found guilty, after a jury trial and by a jury verdict, of Assault, a first-degree misdemeanor in violation of Section 2903.13(A), ORC (Stipulated Fact #5; State Exhibit 7.) The State submitted, and the Respondent stipulated to, certified copies of the court documents related to Ms. Filiaggi's sentencing, and the verdict in Rocky River Municipal Court, Cuyahoga County Case No. 09 CRB 481. (State Exhibit 7, Document Stipulation #1.) A certified copy of a conviction, plea of guilty to, or a judicial finding of guilt of any crime from a court of competent jurisdiction shall be conclusive proof of the commission of all elements of that crime (Rule 4723-16-01(D), OAC.) Ms. Filiaggi was found guilty of "knowingly caus[ing] or attempt[ing] to cause physical harm to another . . ." (Section 2903.13(A), ORC; *see* State Exhibit 7.)

There is also a preponderance of evidence that the person whom Ms. Filiaggi was found guilty of attempting to harm was Patient #1, and that the assault occurred while Patient #1 was under Ms. Filiaggi's care. (*See* Factual Stipulations #5, 12 and 23; *see* State Exhibit 7.) There is a preponderance of evidence that, at a minimum, Ms. Filiaggi had been arguing with Patient #1;

grasped Patient #1 by the jaw in the chin area; and used enough force to get the patient to back away from her (*see* Factual Stipulation #23; *see* Tr., pp. 184-185; *see* State Exhibits 7, 8, 9); and that this behavior either caused physical, verbal, mental, or emotional abuse to Patient #1; and/or that this behavior may reasonably be interpreted as physical, verbal, mental, or emotional abuse. In fact, the patient's neck displayed a dime-sized redness on the right side. (State Exhibit 8.)

**Aggravating and Mitigating Circumstances**

The State's witness, Investigator Dennis Corrigan, testified compellingly that "[i]t is never okay – *it is never okay*, to grab a patient. It is never okay to grab a patient in the face. . ." (Tr., p. 45, emphasis added.) Mr. Corrigan, a trainer certified in Nonviolent Crisis Intervention (State Exhibit 12), testified about the steps Ms. Filiaggi might have taken to avoid the situation with Patient #1. (Tr., pp. 32-33.) Mr. Corrigan stated that the first, immediate steps that a nurse should take when dealing with a difficult patient are to give the patient his/her space, develop a rapport with the patient, and show the patient that the nurse is "on their team." (Tr., p. 32.) Mr Corrigan noted, "if you're arguing with a patient, you're just escalating a problem." (Tr., p 33 ) He stated, "You try to redirect [the patient] by saying, How can I help you? What can I do to make you feel better? What can I do to resolve this for you?" (*Id.*) Mr. Corrigan explained that if the nurse's efforts to deescalate the patient do not work, the nurse should get someone else involved, or change his/her approach in dealing with the patient. (Tr., p. 42.)

Mr. Corrigan described some of his own experiences with difficult patients:

> I've had many patients come at me I've had patients hitting me, spitting at me, chasing me And I'm a big guy. I certainly could have defended myself at any one of those times, but that's not what you're taught in an ER, in an ICU as a nurse You back off There's plenty of people around You're not on a one-to-one basis alone in a cell with somebody You're not on an island There are plenty of people in a hospital that can assist. *There's no reason to ever escalate something to a physical nature*
>
> [ ]
>
> If someone raises their arm, unless you can't walk or run, you back off And I don't care if you have to run and yell for help If someone has become violent, you do not stay in their space because that is just going to escalate the problem

(Tr., pp. 34, 44-45, emphasis added )

The Respondent argued throughout the hearing that Ms Filiaggi did take several of the initial steps described by Mr. Corrigan in how to deal with a difficult patient. (*See e g*, Tr., p. 60.) Ms. Filiaggi did set limits for the patient at the beginning of her shift. (*See* State Exhibit 11; Tr , p. 160.) Ms. Filiaggi was eventually able to get medications administered to Patient #1.

(*See* State Exhibit 11; Tr., p. 165 ) Ms Filiaggi looked up information for Patient #1 in her chart. (*See* State Exhibit 11; Tr., p. 164.) However, some of Ms. Filiaggi's admitted comments to Patient #1 only served to antagonize the patient and escalate the situation. For example, when Patient #1 asked for Ms. Filiaggi's last name, Ms. Filiaggi responded, "I don't give that information out." (State Exhibit 11.) When the patient asked for a pen and complained about the pencil Ms. Filiaggi gave to her, Ms. Filiaggi replied, "This is what we have. Take it or leave it. . . What do you need a pen for anyway?" (Tr., p. 179 ) Ms. Filiaggi admitted in her written statement to police that she was "arguing" with the patient for over an hour. (State Exhibit 11; Tr., p. 221. *See also*, State Exhibits 9, 10.)

Ms. Filiaggi failed to stop an escalating situation that culminated in physical contact with her patient Mr. Corrigan testified that in dealing with difficult patients, the nurse should take the least restrictive means available to address the situation. (Tr., p 55.) He testified that grabbing a patient's jaw is never the least restrictive method to control a patient. (Tr., p. 72.) Ms Filiaggi did not utilize the least restrictive means in dealing with the situation involving Patient #1. The least restrictive means of dealing with Patient #1 would have been for Ms. Filiaggi to remain out of Patient #1's reach. (*See* Tr., p. 45 ) Once there, Ms Filiaggi still could have walked or run away if Patient #1 had raised her hand. (*See* Tr., pp. 44-45.) Even simply blocking or deflecting Patient #1's raised hand would have been acceptable. (*See* Tr., p 65 ) However, Ms. Filiaggi stated that she not only blocked Patient #1's hand, she then grabbed Patient #1's arm. (Tr., p. 183.) Instead of putting herself in a position to get away from Patient #1, Ms. Filiaggi, by grabbing Patient #1's arm, kept Patient #1 in close proximity to her. Ms. Filiaggi stated that Patient #1 moved in towards Ms. Filiaggi, within two (2) inches of Ms. Filiaggi's face. (Tr., p 183.) If indeed the patient did this, the least restrictive means, again, would have been for Ms Filiaggi to walk or run away from the situation. (*See* Tr., p. 44-45.) Even if Ms. Filiaggi could not have stepped backwards, she could have moved to the side and then away from Patient #1; she was not backed up against a wall or in a corner. (*See* Tr , p. 184.) Ms. Filiaggi could have released Patient #1's arm, thereby freeing her own arm to cover her face. Instead, Ms Filiaggi believes she held on to Patient #1's arm (Tr., p. 183.) Ms. Filiaggi stated that Patient #1 was so angry that she "sprayed saliva" into Ms Filiaggi's face. (Tr , p 184.) Ms Filiaggi then "grabbed her chin, jaw, tried to keep it closed and turn it to the side so she couldn't spit at me, bite me, head butt me." (*Id*.) Ms. Filiaggi first testified that she "didn't want to push

her. . didn't want to hit her." (*Id.*) But then, Ms. Filiaggi also stated that she used enough pressure "to get her to back away from me." (Tr., p 185.)

Two witnesses, with no apparent reason to lie, wrote statements indicating that Ms. Filiaggi grabbed the patient by the neck or throat, not the chin. (*See* State Exhibits 8, 9 ) The evidence, even if considered in the light most favorable to Ms. Filiaggi – i e. that she grabbed the patient by the jaw in the chin area, and did not push Patient #1, but used enough force to get her to back away – still supports a finding that Ms. Filiaggi engaged in behavior that caused or might have caused physical abuse to a client. (*See* Rule 4723-4-06(K), OAC.) Grabbing a patient by the jaw in the chin area could also reasonably be interpreted as physical abuse. (*See id* ) Ms. Filiaggi had no therapeutic reason to grab Patient #1 in this situation. The contact was not necessary to restrain the patient so that medication or treatment could be administered, nor was contact necessary to keep the patient from harming herself. (*See* Tr., p 99 )

Nurses should be permitted to defend themselves from physical harm. But Ms. Filiaggi could have avoided any harm by walking away or by only blocking Patient #1's arm, if it were raised. Even if Patient #1 had hit Ms. Filiaggi, it would not have been appropriate for Ms. Filiaggi to grab the patient by the jaw in the chin area and use enough force to move Patient #1 away from her. (*See* Tr., p. 185.) Ms. Filiaggi's actions were aggressive, not defensive as argued by the Respondent. (*See* Tr., p. 264.)

A nurse must have a plan prepared to deal with violent, aggressive patients, especially given the increased incidence of violence against healthcare workers (*See* Tr., pp. 99-100, 122-123, 136.) As Mr. Corrigan stated, "It is never appropriate to grab a patient." (Tr., p. 67 ) At times, a patient's medical conditions and/or mental disorders can and do cause patients to behave inappropriately. (*See* Tr., p. 93 ) A nurse should be prepared to handle these patients and respond properly When asked what she would have done differently that night, Ms. Filiaggi responded, "I would have called for help a lot sooner, but I didn't feel threatened by her until the actual altercation. . . . at the moment it happened so fast, I reacted and maybe I didn't react in the appropriate manner" (Tr., p. 200.)

Ms Filiaggi demonstrated some lack of remorse for her actions toward Patient #1. (*See* Respondent Exhibit D.) According to the AMAC Assessor/Facilitator, Ms. Filiaggi denied that she choked Patient #1, and admitted no wrongdoing during the incident (*Id* ) "Any remorse felt is due to the possibility of the loss of her [Ms. Filiaggi's] nursing license. (*Id* )

The mitigating factors in Ms. Filiaggi's case are many. She has been licensed in the State of Ohio since 1998, with no other Board action being taken against her. (Factual Stipulation #1.) Ms. Filiaggi was also licensed in six (6) other states, and was subject to no disciplinary action in any of those states. (Factual Stipulation #4.)

Ms. Filiaggi submitted an overwhelming number of letters of support from her former co-workers, supervisors and patients. (Respondent Exhibits P-1 through P-42.) These letters demonstrate that Ms. Filiaggi's professionalism, dedication, and compassion for her patients and their families were, and still are, held in high regard in her community.

Over the last five (5) years of her career, Ms. Filiaggi received very favorable performance evaluations. (Respondent Exhibits H, I, J, K.) She consistently received "meets" or "exceeds job requirement" ratings, as well as several "outstanding" ratings. (*See id*.) Very rarely did Ms. Filiaggi receive a "needs improvement" rating. (*See id*.) These evaluations and letters of recommendation recommendations demonstrate that Ms. Filiaggi was a very good nurse, and a valuable employee (Respondent Exhibits H, I, J, K, and Q-1 through Q-7.)

Ms. Filiaggi indicated during her testimony that she has learned important lessons from this experience:

> From all the stuff that I have had to endure in the last year, sitting in from of all of you today, yes, I would certainly have done things a lot different now, and I've learned from that I definitely do call for help And I've been working in the last year without problems and with, liked I said, worse patients
>
> And I've learned to call security very early on, and if I have to reassign myself, then I reassign myself to another patient I'm not afraid to ask for that anymore
>
> [ ]
>
> I'm not going to get confrontational I've learned from this, obviously
>
> [ ]
>
> I have learned, obviously going back and refreshing my nonviolent crisis intervention class, refreshing myself as far as how to defensively protect yourself and the patient I've learned – I am a patient person but I've learned more patience through this I've learned to ask for help a lot sooner, which I'm not afraid to ask for help at all, absolutely not That's what we're there for Everybody's there I believe to work as a team I've learned to talk in a more calm – I don't get upset anymore It's not worth it to me Now that my career is on the line, it's pretty devastating
>
> [ ]
>
> I've learned not every patient is going to be happy with your care And I try my best to get along with everybody, and I treat people and patients and coworkers and friends and family the way I would want to be treated I would never do anything that would intentionally harm or do anything to hurt anybody I'm not that type of person

(Tr., pp 200, 214, 216.)

From the testimony and evidence submitted at the hearing, it appears there were few safeguards in place at SJWS to assist nurses in handling patients such as Patient #1. Cassandra

K. Kamms, R.N., supervised Ms. Filiaggi at both EMH and SJWS hospitals In the letter submitted by Ms. Kamms, she indicated that patients of SJWS who had attempted suicide were allowed to keep the curtains of their ICU rooms drawn shut, and were permitted to keep their personal belongings, telephones (with cords), and bedside supply carts in the room. (Respondent Exhibit N.) Ms. Kamms indicated that recent changes to the policy at SJWS now restrict these patients' movements around the area, and require that their rooms be emptied of all items with which the patient could harm him or herself. (*Id.*) She also stated that the patient would now have a "sitter" in the room, according to the new policy. (*Id.*) Rita Fitch, R.N., also testified about new safety procedures that have been implemented at SJWS (Tr., p. 112.) None of these procedures were in place when the incident involving Ms. Filiaggi and Patient #1 took place. (*See id.*)

In conclusion, it appears that Ms. Filiaggi's innate "flight or fight" response kicked in when confronted with the situation involving Patient #1. Unfortunately, she reacted with the "fight" response, instead of the "flight" response. Patients suffering from any number of mental health or even medical conditions are often not thinking clearly. (*See* Tr., p. 93.) Because of their conditions, these patients may not be able to control the impulses that lead them to behave inappropriately. It is inexcusable for a nurse to retaliate in kind As a nurse, Ms Filiaggi must be prepared at all times to respond with care, not aggression. She must train herself to avoid the "fight" response and find other ways to handle difficult patients

Because of the egregiousness of Ms. Filiaggi's admitted actions, I recommend that a significant penalty be imposed. Ms. Filiaggi's twelve (12) years of experience should have resulted in her knowing how to handle difficult patients. There is a risk that she could repeat this behavior with difficult patients in the future. She was not remorseful in psychological interviews about the harm to the patient. Therefore, I also recommend that permanent practice restrictions be imposed in order to protect the public. I do not recommend permanent revocation due to the fact that Ms. Filiaggi has worked for twelve (12) years with no prior practice issues reported to the Ohio Board of Nursing.

**Findings of Fact**

Having heard the testimony of the witness and the oral argument of counsel, and having examined the exhibits admitted into evidence, I make the following findings of fact and

conclusions of law. To the extent that any findings of fact constitute conclusions of law, they are offered as such. To the extent that any conclusions of law constitute findings of fact, they are so offered.

1. Respondent Kathleen Filiaggi has been licensed with the Ohio State Board of Nursing as a Registered Nurse since March 3, 1998.
2. Ms Filiaggi was employed as a registered nurse at St. John Westshore hospital from October 2007 to March 2009, with no disciplinary action on her employment record, up until the time of her removal.
3. On or about March 6, 2009, Ms. Filiaggi was assigned to work the 7 p m. to 7 a.m. shift in the critical care unit at St. John Westshore hospital. She was assigned to care for two (2) patients.
4. Patient #1 suffered from bi-polar disorder and was off all of her medications. Patient #1 was not supposed to leave her room Patient #1 was agitated, repeatedly left her room and walked out into the hall. Ms. Filiaggi repeatedly asked Patient #1 to return to her room
5. Patient #1 became upset and asked for Ms. Filiaggi's name. Ms. Filiaggi provided her first name, but declined to give Patient #1 her last name. Patient #1 repeatedly asked for Ms. Filiaggi's last name, and Ms. Filiaggi continued to provide her first name only. This aggravated Patient #1.
6. Patient #1 again left her room, went to the nurses' station and asked for a pen to use. Ms. Filiaggi provided a pencil Ms. Filiaggi walked around the nurses' desk to help Patient #1 back to her room
7. While standing in the hallway, Ms. Filiaggi stated that Patient #1 raised her right arm toward Ms. Filiaggi, and Ms. Filiaggi blocked the patient's arm with her left hand and grasped the patient's arm with her left hand. Ms. Filiaggi stated that Patient #1 moved to within two (2) inches of Ms. Filiaggi's face, and screamed and spewed saliva in Ms. Filiaggi's face. I find that at a minimum, Ms. Filiaggi grabbed the patient's jaw in the chin area and used enough force to get Patient #1 to back away from Ms. Filiaggi. Ms. Filiaggi stated to Patient #1, "You are not going to hit me, you are not going to touch me." Ms. Filiaggi denied grabbing Patient #1 by the throat. At 3:30 a.m., a nurse observed a dime-sized redness visible on the right side of Patient #1's neck.

8. Ms. Filiaggi's employment with St. John Westshore hospital was terminated approximately five (5) days after the incident.
9. On or about June 8, 2009, in the Rocky River Municipal Court, Cuyahoga County Case No. 09 CRB 481, Ms. Filiaggi was found guilty, after a jury trial and by a jury verdict, of Assault, a first-degree misdemeanor in violation of Section 2903.13(A), ORC. Ms. Filiaggi was fined two hundred and fifty dollars ($250.00), sentenced to two (2) years community control, and ordered to complete eighty (80) hours of community service, an anger management program, nonviolent crisis intervention training at Elyria Memorial Hospital, and to participate in an assessment to determine whether Ms. Filiaggi should participate in additional training. Ms. Filiaggi has complied with all terms of community control, and has completed eighty (80) hours of community service, the nonviolent crisis intervention program and mental health assessment.
10. On November 20, 2009, the Board issued a Notice of Opportunity for Hearing, notifying Ms Filiaggi that the Board proposed to deny, revoke, permanently revoke, suspend or place restrictions on her license to practice nursing as a registered nurse; reprimand or otherwise discipline her; or impose a fine of not more than five hundred dollars ($500.00) per violation; stating its reasons for such proposed discipline, citing the applicable law at issue and informing Ms. Filiaggi of her right to a hearing. The signed certified mail receipt card was returned to the Board for the Notice of Opportunity for Hearing. Ms. Filiaggi timely requested a hearing.

**Conclusions of Law**

1. Because she holds a license as a registered nurse issued by the Ohio Board of Nursing, Respondent Kathleen Filiaggi is subject to the jurisdiction of the Board in actions taken pursuant to Chapter 4723 of the Ohio Revised Code.
2. Upon sufficient cause to believe a licensee of the Board of Nursing has violated a provision of the Nurse Practice Act, the Board is authorized to take action with respect to that licensee's nursing license. Upon her receipt of the Board's charging document, the Respondent timely requested an evidentiary hearing before the Board took any final action based upon the Board's charges. Upon its receipt of Respondent's request for an administrative hearing, the Board set the matter for hearing, in the manner provided for

by R.C. Chapter 119 (Ohio Administrative Procedure Act), and provided the Respondent with an opportunity to be heard before it took any final action with respect to the Respondent's license as a registered nurse, in the manner provided for by law

3. Section 4723.28(B)(3), ORC, authorizes the Board to discipline a licensee for conviction of, a plea of guilty to, a judicial finding of guilty of, a judicial finding of guilty resulting from a plea of no contest to, or a judicial finding of eligibility for intervention in lieu of conviction for, of a misdemeanor committed in the course of practice The Board is authorized to take action against Ms. Filiaggi's license to practice nursing as a registered nurse where by at least a preponderance of the evidence the State establishes that on or about June 8, 2009, in the Rocky River Municipal Court, Cuyahoga County Case No. 09 CRB 481, Ms. Filiaggi was found guilty, after a jury trial and by a jury verdict, of Assault, a first-degree misdemeanor in violation of Section 2093.13(A), ORC; and that the Assault was committed against Patient #1, in the course of Ms. Filiaggi's practice.

4. Rule 4723-16-01(D), OAC, provides that a certified copy of a conviction, plea of guilty to, or a judicial finding of guilt of any crime from a court of competent jurisdiction shall be conclusive proof of the commission of all elements of that crime.

5. Section 4723.28(B)(12), ORC, authorizes the Board to discipline a licensee for assaulting or causing harm to a patient or depriving a patient of the means to summon assistance The Board is authorized to take action against Ms. Filiaggi's license to practice nursing as a registered nurse where by at least a preponderance of the evidence the State establishes that on or about March 6, 2009, while employed as a registered nurse at St. John Westshore hospital, Ms. Filiaggi assaulted Patient #1. The Board is also authorized to take action against Ms. Filiaggi's license to practice nursing as a registered nurse where by at least a preponderance of the evidence the State establishes that on or about March 6, 2009, while employed as a registered nurse at St. John Westshore hospital, Ms Filiaggi caused harm to Patient #1 when she grabbed Patient #1's jaw in the chin area and used enough force to get Patient #1 to back away from Ms. Filiaggi.

6 Section 4723 28(B)(16), ORC, authorizes the Board to discipline a licensee for violation of Chapter 4723, ORC, or any rules adopted under it. Specifically, Rule 4723-4-06(K), OAC, states that a licensed nurse shall not: (1) Engage in behavior that causes or may cause physical, verbal, mental, or emotional abuse to a client; (2) Engage in behavior

toward a client that may reasonably be interpreted as physical, verbal, mental, or emotional abuse. The Board is authorized to take action against Ms. Filiaggi's license to practice nursing as a registered nurse where by at least a preponderance of the evidence the State establishes that on or about March 6, 2009, while employed as a registered nurse at St. John Westshore hospital, Ms. Filiaggi grabbed Patient #1's jaw in the chin area and used enough force to get Patient #1 to back away from Ms Filiaggi, thereby causing physical abuse to Patient #1 The Board is also authorized to take action against Ms. Filiaggi's license to practice nursing as a registered nurse where by at least a preponderance of the evidence the State establishes that on or about March 6, 2009, while employed as a registered nurse at St John Westshore hospital, Ms. Filiaggi grabbed Patient #1's jaw in the chin area and used enough force to get Patient #1 to back away from Ms. Filiaggi, and that these actions may reasonably be interpreted as physical abuse of Patient #1.

7. Pursuant to Section 4723.28(B), ORC, upon proof that the Respondent has violated a provision of the Nurse Practice Act as set forth in Section 4723 28, ORC, the Board, by a vote of a quorum, may impose one or more of the following sanctions: it may deny, revoke, suspend, or place restrictions on any nursing license issued by the Board; it may reprimand or otherwise discipline a holder of a nursing license; or it may impose a fine of not more than five hundred dollars ($500.00) per violation. Upon sufficient proof, as has been shown in this evidentiary proceeding, that the Respondent has violated the provisions of the Nurse Practice Act as concluded by the Board Hearing Examiner, the Board may implement any of the foregoing disciplinary actions

**Recommendation**

Upon sufficient proof that the Respondent, Kathleen Filiaggi, has violated provisions of the Nurse Practice Act as shown above, it is my recommendation that the Respondent's license to practice as a Registered Nurse be indefinitely suspended for a period of not less than two (2) years, with conditions for reinstatement to be specified by the Board, including but not limited to the following: 1) That Ms Filiaggi obtain a psychological evaluation by a provider selected by the Board; in order to be reinstated, Ms. Filiaggi must comply with all treatment recommendations of the examiner, and the examiner must provide a written opinion to the Board

that Ms. Filiaggi is able to practice in accordance with prevailing standards of safe care; 2) That Ms. Filiaggi complete fifteen (15) hours of continuing education courses, in addition to those hours required for biennial licensure renewal, on ethics, nonviolent crisis intervention, anger management, and patient rights. Further, if Ms. Filiaggi meets these requirements for reinstatement, she should be subject to a probationary period of not less than three (3) years, and permanent practice restrictions including no home care or agency work, unless otherwise approved in advance by the Board; and no work in Alzheimer's, dementia and/or psychiatric units.

This is a recommendation only; it is not a final order. Only the Board has the authority to enter a final order in this administrative action. The Board further has the authority to adopt, modify, or reject this recommendation, and this recommendation shall have no legal effect until and unless adopted by the Board, and a final order is issued by the Board as provided in Chapters 4723 and 119 of the Revised Code.

June 18, 2010
Date

Beth A. Lewis, Attorney at Law
Hearing Examiner, Ohio Board of Nursing

## CERTIFICATE OF SERVICE

I certify that the original of this report and recommendation was served upon the Ohio Board of Nursing at its offices in Columbus, Ohio, by hand delivery, on June 18, 2010.

Beth A. Lewis, Hearing Examiner